

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26767

No. 300
10-48

FILED AUG 21 1949

BIRTH NO. _____		REG. DIST. NO. <u>139</u>		PRIMARY REG. DIST. NO. <u>4224</u>		Registrar's No. <u>57</u>			
1. PLACE OF DEATH a. COUNTY <u>Holt</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Forest City, Mo.</u>		c. LENGTH OF STAY (in this place) <u>8 Yr</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Forest City</u>		d. STREET ADDRESS (If rural, give location) _____			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Otis Claycomb</u>			b. (Middle) _____		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 11 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 28 1872</u>		9. AGE (to years last birthday) <u>76</u> <small>if under 12 months</small> <u>9</u> <small>Days</small> <u>13</u> <small>if under 12 mos. Hours</small> <u>13</u> <small>Min.</small>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John H. Claycomb</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Hecker</u>			14. NAME OF HUSBAND OR WIFE <u>Parmelia Claycomb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>488-14-5198</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Paul C. Claycomb</u> ADDRESS <u>St. Joseph, Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
				ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<u>331X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>728</u> , 1949, to <u>Aug 11</u> , 1949, that I last saw the deceased alive on <u>Aug 9</u> , 1949, and that death occurred at <u>9 a</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>D. B. Perry</u> (Degree or title) _____				23b. ADDRESS <u>Mound City, Mo</u>			23c. DATE SIGNED <u>8-11-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/13/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>F. Forest City</u>		24d. LOCATION (City, town, or county) (State) <u>Forest City, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Aug 11 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Mound City, Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Signed *A. H. Crawford*

Signed _____
Student Embalmer

Licensed Embalmer No. 1824

P. O. Address Grounds, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.